

**Ada County Juvenile Court Services
Weekend Detention Program Health Screen**

Name: _____ **Date:** _____

Date of Birth: _____
Mother: _____ Father: _____
Mother's Home Phone: _____ Father's Home Phone _____
Mother's Work Phone: _____ Father's Work Phone _____

Emergency contact other than parents: _____

Emergency Contact Phone Numbers: (Home) _____ (Work) _____

Allergies: Bee Stings, Hay-Fever, Metals, Food, Other: _____

Are you currently taking any prescribed medications? (Name of Prescribing Doctor, Name of Prescription Medication, Dosage, Time Taken and Reason)

Do you have a history of seizures? Yes ☐ No ☐

Date of last seizure activity:

Do you have a mental health diagnosis? Yes ☐ No ☐

If "yes," please provide information:

Any other significant medical information that the Detention Medical Department should know: _____

Females Only:

Are You Pregnant? Yes ☐ No ☐ Doctor's Name: _____

Number of Months: _____